

ASYLUMS

by
Erving Soffman

One value of Erving Goffman's book, *Asylums*, is that it provides us an opportunity to take a look at mental hospitals from the point of view of the patient. As psychiatrists or as sociologists we tend, he implies, to look at mental hospitals from the point of view of our theories concerning the nature of mental illness and how it should be treated; because we have ideas about what should be there, we tend not to see what actually is there. The patient, however, probably doesn't know anything about our theories; all he knows about the hospital is what he sees. And what he sees, Goffman says, is the "brute fact" that most of what goes on in an institution is determined, not by psychiatric or sociological theory, but by the need to regulate the behavior of many people in a small space with maximum economy and minimum facilities and staff.

In analyzing institutional life as it is actually experienced by the patient, Goffman deals with three processes:

- A) The process of depersonalizing the patient so that he can be more easily dealt with as just another unit in a "batch".
- B) The process of regulating all activities by the "privilege system", which consists essentially of measuring a patient's health in terms of his obedience.
- C) The process by which the patient accommodates himself to the actual conditions of institutional life.

Goffman lists many specific features of each of these processes. These features are outlined in the following pages. There might be some profit for us in looking at each of these features and asking the following questions:

- 1) Does this sort of thing go on in my hospital?
- 2) If it does, and I approve of it, how do I reconcile this with my theoretical view of the function of a mental hospital?
- 3) If it does, and I don't approve of it, what can I do to eliminate it or to minimize its effect on the patient?

The process of depersonalization.

- 1) Is the patient required to sleep, work and play in a restricted number of places, or does he have relative freedom of movement?
- 2) Is the patient always kept with his "batch", or does he have free choice of his companions?
- 3) Is he always subject to the same authorities, or does he have some unregulated areas of activity, opportunities for a "moral holiday"?
- 4) Does staff act primarily in the role of guards?
- 5) How many specific arrangements are dictated simply by the need to "regulate many by few"?
- 6) What is done to minimize split between staff and patients?
 - a) Any normal social intercourse?
 - b) Any use of terms or gestures indicating antagonism or a competition of wills?
 - c) Any use of stereotyped designations, names, attitudes (habitual indifference, loftiness, contempt, etc.)?
- 7) Are the patients regarded as units for processing?
- 8) To what extent do we negate the usual motives for work: pay, advancement, prestige, taking care of one's needs? Do we give a patient any reason to feel he should work?
- 9) Does the amount or nature of the work done bear any relation to the patient's needs, as distinguished from the needs of the institution?
- 10) To what extent does the patient take responsibility for his own domestic arrangements within the hospital?
- 11) To what extent do we enforce him to adjust to "batch" living, and what are our reasons for doing so?
- 12) Is the patient forced to undergo "role dispossession" (i.e., no longer student, parent, spouse, worker, etc.) at entry?
- 13) To what extent do we "trim" or "strip" the patient of all features of self-identification?
 - a) Do we re-identify him by features which he has in common with everyone else?
 - (1) Stereotyped life history
 - (2) Photography
 - (3) Weight
 - (4) Fingerprints
 - (5) Assignment of a number
 - b) Do we disregard the patient's normal privacies (those to which we feel that we have a right, for instance)?
 - (1) Searching his person
 - (2) Removing his personal possessions, and giving him no private locker for storage
 - (3) Undressing
 - (4) Bathing and disinfecting

- c) Do we reconstitute persons as "units", as identical elements of our system?
 - (1) Typed haircut
 - (2) Identical institutional clothing
 - (3) Group instruction in the rules
 - (4) Group assignment to quarters, with knowledge that these can be changed any time the staff arbitrarily decides to do so?
- 14) Do we seem to indicate indifference to the "physical integrity" of the patients?
 - a) Restraint and seclusion
 - b) Beatings
- 15) Do we indulge in verbal and gestural humiliation?
 - a) Tests of obedience
 - (1) Silly errands
 - (2) Humiliating movements
 - (3) Standing at attention
 - (4) Forced deference: "Sir", etc.
 - b) Eat all food with spoon, etc,
 - c) Need to beg for little things which one usually can do for oneself: drink of water, smoke, light, phone
 - d) Humiliating references to patients: obscene names, cursing; negative criticism, particularly in presence of others; teasing or hazing; discussion of the patient in technical jargon
- 16) Do we give the patient a daily round of life that is alien to him?
 - a) No normal heterosexual relationships
 - b) Make-work, menial jobs
- 17) Do we deprive the patient of privacy concerning his personal life, his illness, background, etc.?
 - a) Piles open indiscriminately
 - b) Gossip among staff concerning patients
 - c) Forced group confessions
- 18) Do we subject the patient to public humiliations which are not imposed on the staff?
 - a) Physical examinations lacking privacy
 - b) Collective sleeping
 - c) Doorless, partitionless and seatless toilets?
 - d) Judas windows
 - e) Constantly with people (no time to be alone)
- 19) Do we suspend the usual sanitary arrangements?
 - a) Emptying one's own slop
 - b) Regimented toilet (as to time, place, and duration of stay)
 - c) Unclean food
 - d) Messy quarters
 - e) Soiled towels or other linen
 - f) Wearing sweaty clothes of others
 - g) Dirty bath facilities
 - h) Sleeping with diseased or dying

- 20) Are there other invasions of privacy or self respect?
 - a) Constant surveillance by guards
 - b) Personal possessions handled by others without patient's permission
 - c) Forced grouping without concern for the patient's feelings: on basis of age, race, ethnic group, etc.
 - d) Use of informal modes of address by strangers or by those who cannot be so addressed by the patient
 - e) Censoring mail
 - f) Public visits, no privacy
 - g) Witnessing mortification of significant others without being able to help
- 21) Do we create the following conditions?
 - a) Regimentation: Do only what others are doing
 - 1) Govern all activities by a routine and measured pace
 - 2) Leave no activities to be regulated simply by personal taste
 - 3) Specify minute details of routine: keep hands still, carry only specified items in pocket, use only a specified dole of toilet paper, dress by the numbers, maintain silence, have no pictures or other decorations, do not look around at meals, etc.
 - b) Tyrannization: do only what others tell you to do
 - 1) Do nothing without permission
 - 2) Be subject to any, member of the staff, be at anybody's beck and call
- 22) Do we subject the patient to the "sickness-treatment" rationale of the institution?
 - a) "Looping" - creating a defensive response, then attacking that response as a symptom of illness
 - b) Allow no face-saving reactive expressions
 - c) Interpret all actions, even those normally considered indifferent, as signs of illness.
 - d) Perpetuate the diagnosis as a permanent badge

B. The Privilege System

- 1) Is our definition of rewards and punishments "infantile" and "negative"?
 - a) Infantile punishments: not specific punishments for specific misdeeds but diffuse disadvantages which may attach to any action; do we develop in the patient the feeling that "Big Daddy is watching you?"
 - b) Negative rewards: rewards are not positive values, but only restorations of normal privileges which are stripped from the patient at time of admission. Do we develop in the patient the feeling that he is dependent on us even for those rights which the rest of us consider "natural" and "inalienable"?
- 2) Do we identify the question of release with the privilege system? Do we give the patient the feeling that all he has to do to get out is to behave? Do we confuse "conformity to rules" with "mental health"?

- 3) Do we make the work system part of the privilege system? Do we award easy jobs, etc., to those who "play the game"? In short, is work seen by the patient as punishment or as therapy?

C. Adaptive Processes

The processes by which the patient adapts himself to the depersonalization process and to the privilege system,

- 1) Reactions considered bad in terms of the privilege system:
 - a) Withdrawal, regression, etc.
 - b) Intransigency, refusal to cooperate with staff
- 2) Reactions considered good in terms of the privilege system:
 - a) Colonization: The patient "settles down" in the institution and makes some sort of free world for himself from the limited materials available.
 - b) Conversion: the patient settles down, not because he has made a free world for himself within the institution, but because he has accepted the view that he is totally unable to take care of himself.
 - c) "Playing it cool", which combines surface compliance with internal animosity or indifference.
 - d) Immunization: the easy-going way of those who have never known any better kind of life than that of the institution.
 - e) Identification: becoming a "company man", "stool pigeon", etc,
 - f) Special compensations: Some patients like the institution because it gives them the closest contact they have ever had with the "polite world" of education, manners, cleanliness, etc.